STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A RIJII DIN	A. BUILDING 01			COMPLETED	
	155568		B. WING	NO		03/05/	2012	
				TREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	R			ORT ST			
WILLIAM	ISPORT NURSING	S AND REHABILITATION			MSPORT, IN 47993			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PERCEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	T.	AG	DEFICIENCY)		DATE	
K0000								
	A Life Safety C	Code Recertification	K0000		The creation and submission of			
	1	nsure Survey was			this plan of correction does no			
		the Indiana State			constitute an admission by this			
	Ī				provider of any conclusion set forth in the statement of			
	Department of				deficiences, or of any violation	of		
	accordance wi	th 42 CFR 483.70(a).			regulation.Provider desires that	at		
	Survey Date: (03/05/12		the 2567 plan of correction be considered the letter of credib allegation of compliance on or		е		
	Facility Missaste	000440			after 03/30/2012.			
	Facility Number							
	Provider Numl							
	AIM Number:	100290350						
	Surveyor: Brid	get Brown, Life						
	Safety Code S	-						
	At this Life Sat	fety Code survey,						
	Williamsport N							
	-	was found not in						
		th Requirements for						
	Participation i	n						
	Medicare/Med	icaid, 42 CFR						
	Subpart 483.7	0(a), Life Safety						
		the 2000 edition of						
	the National F							
		FPA) 101, Life Safety						
		napter 19, Existing						
		ccupancies and 410						
	IAC 16.2.							
		6 11						
	This one story	· · · · · · · · · · · · · · · · · · ·						
	determined to	be of Type II (000)						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

	OF CORRECTION OF CORRECTION 155568	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 03/05/2012
	PROVIDER OR SUPPLIER ISPORT NURSING AND REHABILITATION	200 SH	ADDRESS, CITY, STATE, ZIP CODE ORT ST MSPORT, IN 47993	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and spaces open to the corridors. The facility has a capacity of 96 and had a census of 60 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 03/09/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION ID		IDENTIFICATION NUMBER:	A DIIII	DINC	01	COMPLETED	
		155568	A. BUII B. WIN	LDING G		03/05/2	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0048	NFPA 101						
SS=B		ODE STANDARD					
		plan for the protection of all					
	•	heir evacuation in the event					
	of an emergency Based on record		K00)48	K048 NFPA 101 Life Safety		03/30/2012
				=	Code Standard There is a writ	tten	
	interview the fa				plan for the protection of all		
		of the kitchen fire			patients and for their evacuation	on	
	_	n 1 of 1 written fire			in the event of an emergency.		
	safety plans for	safety plans for the facility in the			What corrective actions will I	oe	
	event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan				accomplished for those Residents found to have bee	_	
					affected by the deficient	"	
					practice? 1.) No Residents w	ere	
	that shall provi				directly affected by this deficient		
	following:				practice. 2.) Policy has been		
	(1) Use of alarn	26			updated to reflect the use of th		
	, ,				K-class extinguisher How other		
	` '	on of alarm to the			Residents having the potenti	al	
	fire department				to be affected by the same deficient practice will be		
	(3) Response to				identified and what corrective	_	
	(4) Isolation of				actions will be taken? 1.) All	_	
	(5) Evacuation (of immediate area			Residents have the potential to		
	(6) Evacuation (of smoke			be affected 2.) Policy has bee	n	
	compartment				updated to reflect the use of th		
	(7) Preparation	of floors and			K-Class extinguisher. 3.) All s will be re-educated to the	taff	
	building for eva				appropriate use of the K-Class		
	(8) Extinguishm				extinguisher on 03/27/12. Wha		
	_	ractice affects any			measures will be put into pla		
	-	and visitors in the			to ensure that the deficient		
	•				practice does not recur? 1.)		
	vicinity of the k	attenen.			Fire extinguisher policy has be	en	
	_				updated to reflect the K-Class		
	Findings includ	e:			extinguisher, staff will be re-educated to the change on		
					03/27/12 2.) Staff will be		
	Based on review	v of the facility's			randomly quizzed monthly for	3	
	General Fire Ac	tion Plan on			months then quarterly to test the		

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PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155568		A. BUILDING B. WING	01	COMPLETED 03/05/2012	
	PROVIDER OR SUPPLIER	AND REHABILITATION	200 SH	ADDRESS, CITY, STATE, ZIP CODE HORT ST MMSPORT, IN 47993	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	maintenance su administrator, t include the use extinguisher loo in relationship	he plan did not of the K class fire cated in the kitchen with the use of the ad extinguishing lministrator at the time of he fire d not been		understanding of the K-Class extinguisher and findings will be submitted to the Continuous Quality Improvement committee How the corrective action will be monitored to ensure the deficient practice will not recur? 1.) Any new staff being hired will be instructed on the types of fire extinguisher throughout the facility. Dietary staff will be specifically trained how and when to use the k-classifire extinguisher upon hire and annually thereafter. 2.) Completion date: 03/30/12	g on ass

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PRINTED: 04/03/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED	
155568		B. WING		03/05/2012	
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			200 SH	ADDRESS, CITY, STATE, ZIP CODE HORT ST AMSPORT, IN 47993	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0051 SS=E	A fire alarm syste components, devinstalled according Alarm Code, to prize in any part of the complete fire fire alarm initiation extinguishing system to an approvided that may 200 feet of nurse located in the partite written records or reliable second so reliable second sec	acility failed to e detector ne fire alarm system e compartments eparated from an PA 72, 2-3.5.1 aces served by air ms, detectors shall where airflow tion of the s deficient practice itors, staff, and 17 Hall.	K0051	K051 NFPA Life Safety Code Standard A fire alarm system with approved components, devices or equipment is instal according to NFPA 72, Nation Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation the complete fire alarm systen by manual fire alarm initiation, automatic detection or extinguishing system operatio Pull stations in patient sleepin areas may be omitted provide that manual pull stations are within 200 feet of nurse's stati Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second	led al of n is n. g d

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
155568			B. WIN			03/05/2012
NAME OF F	ADOLUDED OD GUDDU IED			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>		200 SH	ORT ST	
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
IAG	Based on obsermaintenance suadministrator of 1:15 p.m., a condetector was log from an air venton an air venton the maintenant confirmed the emeasurement and observation, arthe air flow could	rvation with the upervisor and on 03/05/12 at orridor smoke ocated 12 inches at near room 112. ce supervisor distance at the time of acknowledged		IAG	source of power is provided. F alarm systems are maintained accordance with NFPA 72 and records of maintenance are ke readily available. There is remannunciation of the fire alarm system to an approved central station. 19.3.4.9.6 What corrective actions will be accomplished for those Residents found to have been affected by the deficient practice? 1.) No Residents, visitors or staff was directly affected by this deficient practic 2.) All smoke detectors have been relocated How other Residents having the potentiat to be affected by the same deficient practice will be identified and what corrective actions will be taken? 1.) All Residents have the potential to be affected 2.) Integrated Electronics, Incorporated (IEI) was contact and relocated all smoke detectors identified and those not identified were relocated away from the neare air vent. What measures will a put into place to ensure that the deficient practice does not recur? 1.) All detectors were relocated by IEI on 03-08-2012 How the corrective action will be monitored to ensure the deficient practice will not recur? 1.) Maintenance Director/or designee will check annually the distance from air vent to smoke detectors to	ire in lept onte
					vent to smoke detectors to	

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		IDENTIFICATION NUMBER: 155568	A. BUILDING B. WING	01	COMPLETED 03/05/2012		
NAME OF PROVIDER OR SUPPLIER WILLIAMSPORT NURSING AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST WILLIAMSPORT, IN 47993				
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
				ensure no smoke detectors ha been relocated accidentally. Completion date: 03/30/2012	s		

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Event ID: **B18521**

Facility ID: 000449

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A. BUILDING	OMPLETED 3/05/2012 (X5) COMPLETION
155568 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST	(X5)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 200 SHORT ST	
200 SHORT ST	
WILLIAMSPORT NURSING AND REHABILITATION WILLIAMSPORT, IN 47993	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	L COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	
The Redeliter of the Electrical Admittally in the	DATE
K0056 SS=E NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 Based on observation and interview, the facility failed to provide complete sprinkler coverage for all areas in 1 of 5 smoke compartments. LSC 19.1.6.2 requires facilities of Type II (000) construction be provided with complete sprinkler protection. This deficient practice affects visitors, staff, and 12 residents in the south A wing smoke compartment. Findings include: Based on observation with the maintenance supervisor and administrator on 03/05/12 at 12:10 p.m., a doorway within the What corrective actions will be	03/30/2012
A wing shower enclosure created accomplished for those Residents found to have been	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A DITH DDIC	01	COMPLETED
155568		A. BUILDING		03/05/2012	
			B. WING		
NAME OF F	PROVIDER OR SUPPLIE	₹		ET ADDRESS, CITY, STATE, ZIP CODE	
				SHORT ST	
WILLIAM	ISPORT NURSING	AND REHABILITATION	WILL	IAMSPORT, IN 47993	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				affected by the deficient	
		hich there was no		practice?	
	sprinkler prote	ection The		1.) No Residents were direct	tly
	maintenance s	upervisor agreed at		affected	, ay
	the time of ob-	servation, sprinkler		2.) Sprinkler heads have be	en
		vided in the shower		installed in the A-Wing showe	l l
	-			How other Residents having	
		ot provide coverage		the potential to be affected by	l l
	for the alcove.			the same deficient practice	
				be identified and what	
	3.1-19(b)			corrective actions will be	
				taken?	
				1.) All Resident have the	
				potential to be affected	
				2.) P.I.P.E(Sprinkler Contra	ctor)
				was contacted 03/08/12 to ins	
				sprinkler heads to the shower	l l
				area identified sprinkler heads	5
				was installed 03/20/12	
				What measures will be put in	nto
				place to ensure that the	
				deficient practice does not	
				recur?	
				1.) Maintenance Director	4:
				conducted a full facility inspect to ensure no other areas were	
				identified. No further areas were	
				identified	,10
				How the corrective action w	
				be monitored to ensure the	
				deficient practice will not	
				recur?	
				1.) Maintenance Director/or	
				designee will annually inspect	all
				areas of the building to ensure	
				sprinkler heads are missing a	
				are in place	
				2.) Completion date: 03/30	/12
1	I		1	į .	l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLET			ETED	
		155568	A. BUILDING B. WING 03/05/2012			2012	
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	t .			ORT ST		
WILLIAM	SPORT NURSING	AND REHABILITATION			MSPORT, IN 47993		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0147	NFPA 101	005 07440400					
SS=D		ODE STANDARD					
		and equipment is in NFPA 70, National					
	Electrical Code.						
	Based on obser		K01	47	K147 NFPA 101 Life Safety		03/30/2012
	interview, the f	acility failed to			Code Standard	.4:-	
		lexible cords was			Electrical wiring and equipmer in accordance with NFPA 70,	nt is	
	not used as a s	ubstitute for fixed			National Electrical Code 9.1.2		
	wiring. NFPA 7	'0, National					
	Electrical Code, 1999 Edition, Article 400-8 requires, unless				What corrective actions will be accomplished for those Residents found to have been		
	specifically per	mitted, flexible			affected by the deficient		
	cords and cable	es shall not be used			practice?		
	as a substitute	for fixed wiring of			1.) No Residents were affect		
		nis deficient practice			2.) All surge strips have bee removed from the dietary	n	
		staff in the kitchen.			department		
					How other Residents having		
	Findings includ	le·			the potential to be affected b	у	
	i mamga merad				the same deficient practice v	vill	
	Rased on obser	vation with the			be identified and what		
	maintenance si				corrective actions will be taken?		
		on 03/05/12 at			1.) All Residents have the		
	12:15 p.m., a p				potential to be affected		
		was used to supply			2.) Maintenance Director		
		hen freezer and			removed surge strip from the dietary department and installed	ed	
	-	he maintenance			an electrical outlet 03/06/12.		
	_				What measures will be put in	ito	
	=	nowledged at the			place to ensure that the		
		ation, the power			deficient practice does not		
	•	used because the			recur? 1.) Dietary staff informed to		
		s were too short to			alert the maintenance departm	nent	
	reach the neare	est electrical outlet.			when new electrical outlets are		
					needed		
	3.1-19(b)				2.) Maintenance Director		

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155568	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 03/05/2012
	ROVIDER OR SUPPLIER		STREET 200 SH	ADDRESS, CITY, STATE, ZIP CODE IORT ST MSPORT, IN 47993	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		removed surge strip from the APPRODEFICIENCY) removed surge strip from the dietary department and insign an electrical outlet 03/06/1 How the corrective action be monitored to ensure the deficient practice will not recur? 1.) Maintenance Director complete monthly a walk-the entire facility to ensure further surge strips are ided. 2.) Completion date: 03	the stalled 2. 1 will he t r will hru of e no entified.

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